DEPARTMENT OF HEALTH
AND HOSPITALS
Aging and Adult Services

OAAS LEVEL OF CARE ELIGIBILITY MANUAL

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Office of Aging and Adult Services (OAAS)

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Revision History Log

Document Title	*OAAS Level of Care Eligibility Manual*
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Revision History

Revised/ Reissued Date	Section	Section Title	Page Number(s)	Revision/Reason for Revision
9/23/11	Section 5.3 (1)	Behavior Pathway	15-16	Removed item *v. Resisted Care* from list. This item was inadvertently included previously, but is not part of the LOC algorithm for triggering the Behavior Pathway.
9/23/11	Section 9.1	Transitioning From One HCBS to Another HCBS Program	44	Revised to streamline use of Level of Care Determination process for participants transitioning from one HCBS to another HCBS Program.
1/05/12	Cover Page	OAAS Level of Care Eligibility Manual	Cover page	Replaced old OAAS Logo with updated DHH/OAAS Logo
1/05/12	All Sections	N/C	All pages	Added OAAS #: OAAS-ADM-11-023 To this manual
5/08/13	Section 5.3	Behavior Pathway	15	Reworded last sentence of first paragraph as follows: …during the look back period as specified in the applicable screening/assessment tool.
5/08/13	Section 6.2	Use of the LOCET to Determine LOC Eligibility	22	Updated hyperlink to OPTS LOCET form
5/08/13	Section 7.5	Review of Physician Involvement, Treatments & Conditions & Skilled Rehab Therapies Pathways	27	Corrected wording on item #9 to read "…in the event that an individual does **not** meet…"
5/08/13	Section 7.7.2	PACE Deeming Procedure	30-32	Changed OAAS-PF-10-002 to OAAS-PF-13-009 to reflect change to this form
5/08/13	Section 7.8	Permanent Waiver of Annual Recertification for PACE Participants	33-36	Added this Section to reflect this new PACE process

Revision History Log (continued)

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Revised/ Reissued Date	Section	Section Title	Page Number(s)	Revision/Reason for Revision
5/08/13	Section 8.0	Degree of Difficulty Questions (DDQ) Overview	37	Revised paragraph wording under Section 8.0 for clarity
5/08/13	All Sections	N/C	All pages	Removed Section References at top of all pages to promote consistency
9/11/13	Section 9.1	Transitioning from one HCBS Program to Another HCBS Program	44	Revised paragraph wording Section 9.1 to remove use of 5 month old MDS-HC to make LOC determination when transitioning between OAAS operated HCBS programs.
9/11/13	Section 9.2	Transitioning Out of a Nursing Facility to HCBS	45	Revised paragraph wording under Section 9.2 to remove deeming status of individuals transitioning out of nursing facility to HCBS.
9/11/13	Appendix A	Waiver HCBS Slides	48	Removed slide indicating deemed status for nursing facility transitions to HCBS
9/11/13	Appendix B	LT-PCS Only Slides	53	Removed slide indicating deemed status for nursing facility transitions to LT-PCS only State Plan
11/18/13	All Sections	N/C	All pages	Changed from OAAS #: OAAS-ADM-11-023 to OAAS-MAN-13-005 to reflect new OAAS Manual numbering system.
11/18/13	Section 3.0	Authority	8	Removed reference to Louisiana Register, Vol. 37, No. 01, January 20, 2011 and referenced LAC 50:II.10154 and 10156.
5/18/15	Section 5.3	Behavior Pathway	16-18	Clarified look-back periods for Behavior Pathway.
5/18/15	Section 7.3	Application of DDQ Process	28	Included Important Note regarding application of DDQs to nursing facility residents.
5/18/15	Section 7.5	Review of Physician Involvement, Treatments & Conditions &	30	Added P.2.h. IV infusion – Central to Table 1

		Skilled Therapies Pathways		
10/08/15	Section 7.3	Application of DDQ Process	28	Included Important Note regarding DDQs not applied to nursing facility residents, or individuals in a hospital (e.g., rehabilitation facility, long term acute care facility, psychiatric hospital, etc.).

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1.0 OVERVIEW

The Level of Care (LOC) determination assures a consistent and reliable process for determining that individuals meet the functional/medical eligibility requirements for admission to and continued stay in a nursing facility or Home and Community-Based Service (HCBS) funded through the Medicaid Program. The functional/medical eligibility process for individuals seeking nursing home admission or HCBS is frequently referred to as the "**nursing facility level of care determination.**"

The LOC determination process also assists persons with long-term or chronic health care needs in making informed decisions and in choosing options that reflect their preferences and meet their needs in the least restrictive way possible.

The Louisiana Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS), is the State agency responsible for oversight and determination of functional/medical eligibility for individuals applying for or who are receiving Medicaid-funded nursing facility care or HCBS.

Program services administered by the OAAS are provided to eligible individuals with a range of functional and cognitive abilities. Improving the ability of the health care delivery system to respond to the needs of all of these individuals in an equitable, streamlined, and fiscally responsible manner, is a primary and ongoing goal and responsibility of the OAAS.

2.0 PURPOSE AND SCOPE

The purpose of this manual is to provide instruction and guidance regarding the uniform Level of Care (LOC) eligibility criteria and LOC review processes that must be followed by the OAAS and its designees.

IMPORTANT NOTE:

This manual shall be used in conjunction with the Department of Health and Hospitals (DHH) Medicaid manuals and other Office of Aging Program Manuals which provide more detail about policies and procedures regarding Long-Term Care

HCBS programs and services. References are made throughout this manual, as applicable, to guide the reader when specific program and other requirements are beyond the scope of this manual.

3.0 AUTHORITY

This document draws from a combination of federal and state laws, as well as from Department of Health and Hospitals (DHH) policy which specify the standards and procedures that must be followed in determining medical/functional eligibility for nursing facility services and HCBS programs. Should a conflict exist between this manual's content and pertinent federal and state laws or regulations, the latter will take precedence.

The primary authority and basis for the protocols and directives outlined in this LOC Eligibility policy manual come from The Nursing Facilities—Standards for Payment, Level of Care Determination (LAC 50:II.10154 and 10156) Title 50, PUBLIC HEALTH—MEDICAL ASSISTANCE, Part II. Medical Assistance Program, Subpart 3. Standards for Payment, Chapter 101. Standards for Payment for Nursing Facilities, Subchapter G. Levels of Care.

(a) **Applicability.** The rules and polices referenced in this manual apply to nursing facility admissions and services funded through Medicaid HCBS Waivers, Long Term Personal Care Services (State Plan Services), and the Program for all Inclusive Care for the Elderly (PACE).

(b) **Program Administration and Operation.** The Department of Health and Hospitals (DHH), in partnership with the Centers for Medicare and Medicaid (CMS), federal agency, and the Bureau of Health Services Financing (Bureau/BHSF), administers the Medicaid-reimbursed programs and services operated by the Office of Aging and Adult Services (OAAS).

The *Bureau* is the Louisiana Medicaid Program. The Bureau, in partnership with the OAAS, develops program rules, regulations,

policies, and procedures for the operation and oversight of these programs.

4.0 RECIPIENT ELIGIBILITY REQUIREMENTS

Each long-term care program administered by the OAAS has specific recipient eligibility requirements which must be met in order for an individual to be determined eligible. These eligibility requirements can be grouped into three major categories:

- Medicaid financial eligibility;
- Program requirements, and;
- Medical/functional eligibility.

This Section provides a brief overview of both financial eligibility and program requirements, with a primary focus on the medical/functional eligibility determination processes utilized by the OAAS and its designees.

4.1 Medicaid FINANCIAL ELIGIBILITY

Financial eligibility for Medicaid-funded programs is determined by local Medicaid Eligibility staff. Maximum income and resource limits are announced each year by the Medicaid division of DHH. OAAS Program *Fact Sheets* include a summary of current income and resource limits, and are posted on the OAAS website at: www.oaas.dhh.louisiana.gov.

Medicaid financial eligibility rules are complex. Certain income and resources may be excluded from these limits. Due to this complexity, OAAS employees and designees are instructed to refer individuals who are not yet Medicaid eligible to the Medicaid Eligibility office.

4.2 Program Requirements

In addition to meeting Medicaid financial and functional/medical eligibility requirements, individuals must also meet all program specific requirements before they can be determined eligible for a particular program. Specific program requirements are defined in program rules, policies, and program manuals.

Medicaid Program Manuals may be accessed by visiting the online *Provider Manuals* posted on the LA Medicaid Provider Relations website at: http://www.lamedicaid.com, or the OAAS website at: www.oaas.dhh.louisiana.gov.

4.3 FUNCTIONAL/MEDICAL ELIGIBILITY

The OAAS utilizes prescribed, uniform screening and assessment tools to gather critical data for the purpose of determining whether an individual meets the nursing facility level of care criteria, as set forth in state and federal rules and regulations.

Individuals who are approved by OAAS, or its designee, as having met nursing facility level of care, must continue to meet medical/functional eligibility criteria on an ongoing basis.

Louisiana establishes Nursing Facility Level of Care via the use of scientifically validated and reliability tested screening and assessment tools which are utilized upon initial application and program eligibility redetermination periods.

There are several, distinct *pathways* by which an individual can be determined to meet Louisiana's Nursing Facility Level of Care eligibility criteria. These pathways are described in detail in Section 5.0 of this manual.

5.0 LEVEL OF CARE PATHWAYS

Several potential avenues of functional and medical eligibility are investigated by the OAAS or its designees during the LOC eligibility determination process. These avenues are called *pathways*. These pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations.

The distinct LOC pathways are:

- Activities of Daily Living
- Cognitive Performance
- Behavior
- Service Dependency
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies

When specific eligibility criteria are met within a pathway, that pathway is said to have *triggered*.

The Medicaid program defines Nursing Facility Level of Care for Medicaid eligible individuals as the care required by individuals who meet any one of the established level of care pathways as described in this manual.

In order to meet the nursing facility level of care criteria, an individual must meet eligibility requirements in only one of the pathways described in this Section.

The Levels of Care pathways elicit specific information within a specified evaluation period called a *look-back period*, regarding the individual's:

- functional capabilities;
- receipt of [human] assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) during the specified look-back period;
- current medical treatments and conditions, and;
- other aspects of the individual's life.

5.1 ACTIVITIES OF DAILY LIVING (ADL) PATHWAY

The intent of the ADL pathway is to determine the individual's self-care performance in Activities of Daily Living (ADLs) during a specified look-back period (e.g., the last 3 days, last 7 days, last 14 days, etc.) from the Assessment Reference Date (ARD). The Assessment Reference Date is the specific end point for the specified look-back periods in the assessment process.

Almost all LOC assessment items refer to the individual's status over a designated time period, referring back in time from the Assessment Reference Date (ARD). Most frequently, this look-back period, also called the *observation* or *assessment* period, is a 3-day, 7-day, 14-day, or longer period of time as specified by the LOC assessment or screening instrument. The observation, or look-back period, ends on the Assessment Reference Date. In other words, the certified assessor is "looking back" from the Assessment Reference Date (ARD) in order to capture the data requested for that look-back period on the LOC screening or assessment instrument. (Refer to Section 6.0 of this manual for information on Uniform Assessment Instruments).

The Activities of Daily Living (ADL) pathway is the pathway most often triggered for OAAS' target population. The ADL pathway identifies those individuals with a significant loss of independent function as measured by the amount of assistance **received** from another person during the specified look-back period.

The ADLs for which the LOC screening and assessment tools elicit information are:

i. locomotion—moving around in the individual's home;
ii. dressing—how the individual dresses/undresses;

iii. eating—how food is consumed (does not include meal preparation);

iv. bed mobility—moving around while in bed (includes sitting up and lying down once in the bed);

v. transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);

vi. toileting—includes getting on and off the toilet, wiping, arranging clothing, etc.;

vii. personal hygiene (excludes baths/showers); and

viii. bathing (excludes washing of hair and back).

Since an individual can vary in ADL performance from day to day, OAAS trained and certified assessors are taught to capture the total picture of ADL performance over the specified look-back period.

In order for an individual to meet the LOC eligibility criteria in the ADL pathway, the individual must score at the:

a. limited assistance level or greater (as defined by the LOC screening/ assessment instrument) on toilet use, **or** transferring, **or** bed mobility; **or**

b. extensive assistance level or greater (as defined by the LOC screening/ assessment instrument) on eating.

5.2 COGNITIVE PERFORMANCE PATHWAY

The Cognitive Performance pathway identifies individuals who experienced difficulty during the specified look-back period in the areas listed below:

a. short term memory which determines the individual's functional capacity to remember recent events;

b. cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:

i. planning how to spend his/her day;

ii. choosing what to wear; or

iii. reliably using canes, walkers or other assistive devices/equipment, if needed;

c. making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

In order for an individual to meet the LOC eligibility criteria in the Cognitive Performance pathway, the individual must have the type and level of impairment (during the specified LOC look-back period) in any one of **a.** through **m.** below:

a. Individual is severely impaired in daily decision making (i.e., never or rarely made decisions); **or**

b. Individual has a short term memory problem **and** daily decision making is moderately impaired (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times); **or**

c. Individual has a short term memory problem **and** daily decision making is severely impaired (i.e., never or rarely made decisions); **or**

d. Individual has a short term memory problem **and** is sometimes understood (i.e., ability is limited to making concrete requests); **or**

e. Individual has a short term memory problem **and** is rarely or never understood; **or**

f. The individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times), **and** the individual is usually understood (i.e., difficulty finding words or finishing thoughts; prompting may be required); **or**

g. The individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at

all times), **and** the individual is sometimes understood (i.e., ability is limited to making concrete requests); **or**

h. The individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times), **and** the individual is rarely or never understood; **or**

i. The individual is severely impaired in daily decision making (i.e., never or rarely made decisions), **and** the individual is usually understood (i.e., has difficulty finding words or finishing thoughts and prompting may be required); **or**

j. The individual is severely impaired in daily decision making (i.e., never or rarely made decisions), **and** the individual is sometimes understood (i.e., ability is limited to making concrete requests); **or**

k. The individual is severely impaired in daily decision making (i.e., never or rarely made decisions), **and** the individual is rarely or never understood; **or**

l. The individual is minimally impaired in daily decision making (i.e., has some difficulty in new situations or decisions poor and requires cueing/ supervision in specific situations only), **and** the individual is sometimes understood (i.e., ability is limited to making concrete requests); **or**

m. The individual is minimally impaired in daily decision making (i.e., some difficulty in new situations or decisions poor and requires cueing/ supervision in specific situations only), **and** the individual is rarely or never understood.

5.3 BEHAVIOR PATHWAY

The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the community during the look-back period, as specified in the applicable screening/assessment tool.

The behavior challenges may include:

a. wandering;

b. verbally or physically abusive behavior;

c. socially inappropriate behavior;

d. delusions or hallucinations.

In order for an individual to meet the LOC eligibility criteria in the Behavior pathway, the individual must have:

1) exhibited any one of the following behaviors on at least four (4) to six (6) days of the screening tool's seven-day look-back period but less than daily:

    i. wandering;

    ii. verbally abusive;

    iii. physically abusive; **or**

    iv. socially inappropriate or disruptive; **or**

2) exhibited any one of the following behaviors **daily** during the screening tool's seven-day look-back period:

    i. wandering;

    ii. verbally abusive;

    iii. physically abusive; **or**

    iv. socially inappropriate or disruptive; **or**

3) experienced delusions or hallucinations within the screening tool's seven-day look-back period that impacted his/her ability to live independently in the community; **or**

4) exhibited any one of the following behaviors daily during the assessment tool's three-day look-back period and behaviors were not easily altered:

    i. wandering;

    ii. verbally abusive;

    iii. physically abusive; **or**

    iv. socially inappropriate or disruptive; **or**

5) Experienced delusions or hallucinations within the assessment tool's three-day look-back period that impacted his/her ability to live independently in the community.

5.4 SERVICE DEPENDENCY PATHWAY

The intent of this pathway is to identify individuals who are currently enrolled in and receiving services from either a Waiver or Long Term Personal Care (LT-PCS) State Plan Program, Program for All Inclusive Care for the Elderly (PACE) program, or a Medicaid reimbursed nursing facility, and who were receiving such services prior to 12/01/2006 with **no break in service** to the present day.

The Service Dependency pathway is only applicable to individuals who meet **all** four (4) of the criteria listed below:

1) They are currently enrolled in and receiving services from either a Waiver, LT-PCS State plan Program, PACE program, or a Medicaid reimbursed nursing facility, **and**

2) They were receiving these same services prior to 12/01/2006, **and**

3) They have had no break in service to the present day, **and**

4) They require these services in order to maintain current function (as determined by the OAAS or its designees).

It should be noted that an individual who is eligible for approval in the Service Dependency pathway, may subsequently trigger/meet in another LOC pathway.

The Service Dependency pathway should be used only in the event that no other pathway triggered.

5.5 PHYSICIAN INVOLVEMENT PATHWAY

The intent of the Physician Involvement pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for him/herself.

- Physician visits and Physician Orders are investigated, with consideration given to physician visits in the last 14 days, excluding emergency room exams, physician orders in the last 14 days, order renewals without change and hospital inpatient visits. **Physician visits in a nursing facility may be counted.**

In order for an individual to be approved in the Physician Involvement pathway, the individual must have:

a. one day of doctor visits **and** at least 4 new order changes within the last 14 days; **or**

b. at least 2 days of doctor visits **and** at least 2 new order changes within the last 14 days; **and**

c. supporting documentation for the specific condition(s) identified, as deemed applicable by OAAS.

Acceptable supporting documentation may include:

i. Intake analyst/certified assessor notes in the specified LOC screening/assessment tool(s) indicating the presence of one of the conditions noted in Subsection 5.5 of this manual.

ii. a copy of the physician's orders;

iii. home health care plans, hospital/nursing facility discharge plan, physician's notes, documenting the diagnosis, treatments and conditions within the designated time frames; **or**

iv. OAAS-PF-06-009 Statement of Medical Status (SMS) form documenting the individual's medical status and condition.

The Physician Involvement pathway is approved for time limited services/ length of stay, as deemed applicable by the OAAS or its designees.

5.6 TREATMENTS AND CONDITIONS PATHWAY

The intent of the Treatments and Conditions pathway in the LOC process is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for him/herself. The following treatments and conditions are investigated:

a. stage 3-4 pressure sores in the last 14 days;

b. intravenous feedings in the last 7 days;

c. intravenous medications in the last 14 days;

d. daily tracheostomy care, daily ventilator/respiratory usage, daily suctioning in the last 14 days;

e. pneumonia in the last 14 days **and** the individual has associated ADL/IADL needs or restorative nursing care needs;

f. daily respiratory therapy (must be provided by a qualified professional) in the last 14 days;

g. daily insulin injections with two or more order changes in the last 14 days: supporting documentation shall be required for the daily insulin usage **and** the required order changes;

h. peritoneal or hemodialysis in the last 14 days.

In order for an individual to be approved in the Treatments and Conditions pathway, the individual must have:

a. any one of the conditions listed in items **a.** through **h.** above; **and**

b. supporting documentation for the specific condition(s) identified, as deemed applicable by OAAS or its designees.

Acceptable supporting documentation may include:

i. Intake analyst/certified assessor notes in the specified LOC screening/assessment tool(s) indicating the presence of one of the conditions noted in Subsection 5.6 of this manual;

ii. a copy of the physician's orders;

iii. home health care plans, hospital/nursing facility discharge plan, physician's notes, documenting the diagnosis, treatments and conditions within the designated time frames; **or**

iv. OAAS-PF-06-009 Statement of Medical Status (SMS) form documenting the individual's medical status and condition.

This pathway is approved for time limited services/length of stay, as deemed applicable by the OAAS or its designees.

5.7 SKILLED REHABILITATION THERAPIES PATHWAY

The intent of this pathway is to identify individuals who have received, or are scheduled to receive, at least 45 minutes of physical therapy, occupational therapy, or speech therapy within the specified 7-day look-back period, or within the specified 7-day ***look-forward*** period from the LOC screening/assessment Assessment Reference Date (ARD).

In order for an individual to be approved in the Skilled Rehabilitation Therapies pathway, the individual must have:

a. received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the last seven (7) days (i.e., 7-day look-back period); **or**

b. at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled for the next seven days (i.e., 7-day look-forward period); **and**

c. supporting documentation for the specific condition(s) identified as deemed applicable by OAAS.

This pathway is approved for time limited services/length of stay, as deemed applicable by the OAAS or its designees.

Acceptable supporting documentation may include:

i. a copy of the physician's orders for the scheduled therapy;

ii. home health care plan notes indicating the therapy received during the required look-back period;

iii. progress notes indicating the physical, occupational, and/or speech therapy received or scheduled;

iv. nursing facility or hospital discharge plans indicating the therapy received for the required look-back period, or therapy scheduled for the required look-forward period;

v. Intake analyst/certified assessor notes in the specified LOC screening/assessment tool(s) indicating the presence of one of the conditions noted in Subsection 5.7 of this manual; **or**

vi. OAAS-PF-06-009 Statement of Medical Status (SMS) form documenting the individual's medical status and condition.

6.0 UNIFORM LOC SCREENING AND ASSESSMENT TOOLS

This Section provides a description of the prescribed uniform LOC screening and assessment tools and related processes utilized by the OAAS and its designees to assess and determine an individual's initial and ongoing LOC eligibility status.

6.1 LEVEL OF CARE ELIGIBILITY TOOL (LOCET)

The Level of Care Eligibility Tool (LOCET) is an algorithm-based screening tool used by the OAAS and by OAAS designated entities during the initial intake screening process to ascertain whether an individual "presumptively" meets the Nursing Facility LOC eligibility criteria, as described in Section 5.0, or via application of Degree of Difficulty Questions described in Section 8.0 of this manual, for OAAS operated programs.

The LOCET has been designed to be an automated, easily administered, person-centered screening tool. The LOCET is compatible with the congressionally mandated Resident Assessment Instrument (RAI) used in nursing homes in the United States and several countries abroad (the RAI is also referred to as the *Minimum Data Set*, or *MDS)*. This compatibility fosters and promotes continuity of care through a *seamless* assessment system across multiple facility-based and home and community-based settings.

6.2 Use of the LOCET to Determine LOC Eligibility

The LOCET screening tool is primarily administered over the telephone by trained SPOE staff to individuals calling for admission to OAAS operated HCBS, or nursing facility services.

The Single Point Of Entry (SPOE) concept and use of the LOCET screening tool by OAAS trained SPOE staff, is designed to meet the following primary functions:

1) provide individuals, their caregivers, and their families comprehensive and objective information about community services, and program eligibility criteria that facilitates informed choices;

2) assist with navigation, linking consumers with the opportunities, services, and resources available to help meet their particular needs;

3) consistent delivery of a streamlined LOC screening process that fosters a person centered approach, and facilitates appropriate access to care;

4) streamline consumers' transitions along the continuum of care;

5) reduce barriers to accessing health care services and improve care delivery in a cost-effective and efficient manner.

The information required on the LOCET must be provided by the individual requesting services, or by someone who is sufficiently familiar with the individual to provide all required information, completely and accurately (e.g., responsible representative, family, nursing facility staff, hospital discharge planner staff).

The telephone administered LOCET renders a "presumptive" LOC eligibility status. This means that the individual is *assumed* to meet at least one of the LOC pathways described in Section 5.0, or via application of Degree of Difficulty Questions described in Section 8.0 of this manual, as indicated by the LOCET screening results. The presumptive LOCET screening results are **verified by the OAAS or its designees** within state and federal rules and regulations.

The OAAS Participant Tracking System (OPTS) LOCET *User Manual*, as well as the LOCET form itself, include step-by-step instructions and stipulate the specified look-back periods in which to measure the person's abilities. A copy of the OPTS LOCET form may be obtained by visiting the OAAS website at: www.oaas.dhh.louisiana.gov.

6.3 THE RESIDENT ASSESSMENT INSTRUMENT (RAI), MINIMUM DATA SET-HOME CARE (MDS-HC)

The RAI, MDS-HC is a scientifically validated and reliability tested comprehensive and standardized instrument for evaluating the needs, strengths, and preferences of elderly and individuals with adult onset disabilities. The RAI, MDS-HC has been designed to be compatible with the congressionally mandated Resident Assessment Instrument (RAI), MDS used in nursing homes in the United States and several countries abroad. Such compatibility promotes continuity of care through a *seamless* assessment system across multiple health care settings, and promotes a person - centered evaluation.

The RAI, MDS-HC consists of the Minimum Data Set for Home Care (MDS-HC) and the Client/Clinical Assessment Protocols (CAPs).

- The ***Minimum Data Set for Home Care (MDS-HC)*** is the assessment component that enables a home care provider to assess multiple key domains of function, health, social support, and service use. Particular MDS-HC items also identify clients who could benefit from further evaluation of specific problems and risks for functional decline. These items, known as "triggers," link the MDS-HC to a series of problem-oriented CAPs.

- The ***Client/Clinical Assessment Protocols (CAPs***) focus on a person's function and quality of life, assessing the person's needs, strengths and preferences. They are utilized by OAAS trained and certified assessors in the care planning process, and facilitate referrals when appropriate. When used on multiple occasions (e.g., upon reassessment), the CAPs provide the basis for an outcome-based assessment of the person's response to care or services.

- The MDS-HC assessment tool is administered by certified assessors in accordance with OAAS program policies and procedures to verify that an individual applicant/participant meets the Level of Care eligibility criteria in at least one of the Level of Care Pathways described in Section 5.0, or via application of Degree of Difficulty Questions described in Section 8.0 of this manual.

6.4 USE OF THE MDS-HC TO DETERMINE LOC ELIGIBILITY

Some of the primary functions of the MDS-HC assessment process include:

- Verification of the presumptive LOCET screening results obtained by trained Single Point of Entry staff during the initial, telephone intake process, and;

- Verification that the individual continues to meet the required functional/medical LOC eligibility criteria upon subsequent reassessments (e.g., annual, follow up, status change reassessments) as specified in state and federal rules and regulations.

The face-to-face MDS-HC assessment is completed by OAAS trained and certified assessor staff in accordance with OAAS' *Mandatory Certification* policy and procedures.

In the interest of quality assurance, OAAS staff has the authority to require an MDS-HC assessment be repeated by a certified assessor, or to conduct the face-to-face MDS-HC assessment him or herself. In these situations, the OAAS will make the final determination regarding whether or not the individual meets the required LOC eligibility criteria based on the assessment results and supporting documentation, as applicable.

7.0 MDS-HC LOC REVIEW PROCESS

The intent of this Section of the manual is to provide a detailed overview of the process steps that shall be utilized by all certified MDS-HC assessors when determining if an applicant/participant meets the functional/medical Level of Care eligibility criteria on initial and redetermination MDS-HC assessments.

The MDS-HC LOC review process described in this Section of the manual has been numbered as a means of assuring ease of reference, and to provide a consistent, standardized, LOC review process by OAAS or its designees:

7.1 FACE-TO-FACE MDS-HC

1. The certified MDS-HC assessor completes a face-to-face MDS-HC assessment, in accordance with programmatic guideline, as part of the initial intake process for individuals applying for HCBS programs, or for individuals undergoing a LOC reassessment per state and federal guidelines and OAAS LOC reassessment protocols for continuation of services.

2. Once the certified assessor has completed the MDS-HC, he/she must systematically review the MDS-HC data to verify that the individual has met the required nursing facility LOC eligibility criteria.

7.2 Review of ADL, Cognitive Performance and Behavior Pathways

3. The certified assessor first reviews the three (3) pathways that may trigger a LOC determination within the automated MDS-HC software application. These pathways include the:

    - ADL Pathway;
    - Cognitive Performance Pathway, and the;

    - Behavior Pathway.

    One or more of the three (3) pathways listed above, will be displayed in the triggered CAPs report of the MDS-HC if the assessment data indicates that the triggering responses were present during the specified MDS-HC look-back period(s). <u>As noted previously, a trigger in only one LOC pathway is sufficient for the individual to meet the LOC eligibility criteria.</u>

4. After the certified assessor has reviewed the MDS-HC data, as described in step number 3 above, he/she determines if the individual has met one or a combination of the three pathway(s) (i.e., ADL, Cognitive Performance, and/or Behavior pathway) as evidenced by the MDS-HC CAPs report.

If the triggered MDS-HC CAPs indicate that the individual has triggered in at least one of the LOC pathways noted in step number 3 above, the certified assessor stops the LOC Review process and continues on with the Care Planning process.

If the LOC Review process described in step number 3 above indicates that the individual has not triggered in at least one of the LOC pathways noted in step number 3 above, the certified assessor continues on to the Degree of Difficulty Questions (DDQs) process described in Section 7.3 and Section 8 of this manual.

7.3 Application of Degree of Difficulty Questions (DDQ) Process (Previously known as "0/8 Protocol")

5. If the certified assessor is conducting an "Initial" MDS-HC assessment (i.e., new applicant, or applicant applying for a brand new program), **and** the individual did not trigger the ADL, Cognitive Performance, and/or Behavior pathways, he/she must apply the **Degree *of Difficulty Questions (DDQs)*** process (previously referred to as the "0/8 Protocol") as described in this Section 8 of the manual.

   The DDQ process takes into consideration the degree of difficulty (as described in Section 8 of this manual) that an individual may be experiencing in completion of the ADLS.

   - **Important note regarding application of DDQs on MDS-HC Reassessments**: The DDQ criteria for meeting LOC on the ADL pathway shall not be routinely applied on MDS-HC reassessments (e.g., Annual, Follow Up, or Status Change assessments), unless the individual meets the criteria described in Subsection 8.5 of this manual.

   - **Important note regarding application of DDQs for individuals in a nursing facility or hospital:** The DDQ criteria is **NOT APPLIED** when assessing individuals in a nursing facility or hospital (e.g.

rehabilitation facility, long term acute care facility, psychiatric hospital, etc.) .

6. If the individual undergoing an initial MDS-HC assessment meets the DDQ criteria as described in Subsections 8.2 and 8.3 of this manual, certified **assessor must document in the MDS-HC Notebook that the individual has met the ADL LOC pathway per application of the DDQs.**

7. If the individual does not meet the ADL LOC pathway via application of the DDQs, or the assessor determines that the individual does not meet the criteria for application of the DDQs as described in Section 8 of this manual, he/she must proceed to the next LOC review process steps described below.

7.4 Review of Service Dependency Pathway

8. If the individual being assessed is undergoing an MDS-HC Reassessment (i.e., Annual, Follow Up, or Status Change) and he/she failed to meet the LOC criteria described in Section 5.0, or via application of Degree of Difficulty Questions described in Section 8.0 of this manual, the certified assessor must determine if the individual is eligible for application of the *Service Dependency pathway.*

    - Approval of the Service Dependency pathway using the MDS-HC requires that all of the criteria described in Section 5.4 of this manual, be met in order to qualify in this LOC pathway. The certified assessor may require the assistance of the OAAS Regional Office staff if he/she cannot verify that the individual was receiving services in a Medicaid nursing facility, or an HCBS program prior to 12/01/2006 with no break in services up to the present time.

7.5 Review of Physician Involvement, Treatments & Conditions & Skilled Rehabilitation Therapies Pathways

9. In the event that an individual does **not** meet the ADL (5.1), Cognitive Performance (5.2), Behavior (5.3), or Service Dependency Pathway (5.4) LOC eligibility pathway(s) criteria, or ADL pathway via application of Degree of Difficulty Questions described in Section 8.0 of this manual, the certified assessor must carefully examine the MDS-HC Section items noted in **Table 1** below. This process will focus on the possibility of the individual meeting the Physician Involvement, Treatment and Conditions, and/or the Skilled Rehabilitation Therapies pathways described in Subsection 5.5, 5.6, and 5.7 of this manual.

Review the MDS-HC Items noted in Table 1 below in order to determine if the individual may meet the Physician Involvement, Treatments and Conditions, and/or the Skilled Rehab Therapies LOC pathway(s)		
MDS-HC Item	***Short Description***	***MDS-HC Score***
J.1.u.	Pneumonia	1 or 2
N.2.a.	Pressure Sores	3 or 4
P.1.f.	Physical Therapy	≥ 45 min
P.1.g.	Occupational Therapy	≥ 45 min
P.1.h.	Speech Therapy	≥ 45 min
P.2.b.	Respirator	1, 2 or 3
P.2.c.	Other Respiratory Treatments	1, 2 or 3
P.2.g.	Dialysis	1, 2 or 3
P.2.h.	IV infusion – Central	1, 2, or 3
P.2.i.	IV infusion – Peripheral	1, 2 or 3
P.2.m.	Tracheostomy care	1, 2 or 3
P.2.o.	Occupational Therapy	1, 2 or 3
P.2.p.	Physical Therapy	1, 2 or 3

Table 1

- If upon review of the MDS-HC assessment information noted in **Table 1** above, the certified assessor determines that the individual may qualify for approval in the Physician Involvement, Treatments and Conditions, and/or Rehabilitation Therapies pathway(s), he/she must provide

additional supporting documentation, as described in Subsections 5.5, 5.6, and 5.7 of this manual, prior to making a final LOC determination.

- The documentation for supporting eligibility under the Physician Involvement, Treatments and Conditions and Skilled Rehabilitation Therapies pathways will be reviewed by the OAAS or its designees in order to determine if the conditions and/or treatments indicated are supported. If there is any question regarding whether or not the documentation supports the conditions and /or treatments, the reviewer must request assistance from a supervisor, and/or the OAAS regional office staff. Guidance will be provided as necessary to help determine which decision is appropriate. Additional documentation, as applicable, may be required and requested by the OAAS or its designees. These situations should be rare, but are possible.

- If the documentation supports the Physician Involvement, Treatments and Conditions, and/or the Skilled Rehabilitation pathway, the LOC eligibility criteria is met.

7.6 Eligibility in Only One Pathway is Required to Meet LOC Eligibility Criteria

- It is important to remember that eligibility in only **one** pathway is required in order to meet the Nursing Facility LOC eligibility criteria.

- As soon as an individual has met on at least one of the LOC pathways described in this review process, **the certified assessor can stop at that point and proceed with the care planning process.** (Refer to Appendix A and Appendix B for a visual depiction of the LOC Review Process)

7.7 Additional LOC Review for Program for All Inclusive Care for the Elderly (PACE)

Individuals wishing to access PACE services must initially meet nursing facility LOC eligibility criteria in order to enroll in that program. **If, upon annual reassessment,**

the individual fails to meet the LOC process described in Sections 5.0 and 8.0 of this manual, there is another LOC eligibility option available only to PACE participants. That process is referred to as "Deeming Continued Eligibility." This is possible due to the federal guidelines that allow states to provide this option. This process is described as follows:

7.7.1 Deeming Process Overview

If the Louisiana Office of Aging and Adult Services (OAAS) determines upon annual reassessment that a PACE participant no longer meets the nursing facility level of care criteria as described in Sections 5.0 and 8.0 of this manual, the participant may be deemed to continue to be eligible for PACE until the next annual reassessment period. The PACE provider may request "deemed continued eligibility" based on the following criteria:

- The participant no longer meets the nursing facility level of care criteria but would reasonably be expected to become eligible within six month in the absence of continued coverage under the program.

- The participant's medical record and plan of care support deemed continued eligibility.

Important note: It is critical that the PACE provider follow all OAAS policies and procedures related to determination of Level of Care prior to requesting Deemed Continued Eligibility for failure to meet Nursing Facility Level of Care on annual reassessment.

7.7.2 PACE Deeming Procedure

The procedures noted below will be used to determine if deemed continued eligibility criteria is met for PACE participants who do not meet nursing facility level of care upon annual reassessment.

A. PACE Provider Responsibilities:

1. Within five (5) business days of notification of a PACE participant not having met nursing facility level of care criteria, the PACE provider will submit a request for Deemed Continued Eligibility Form **- OAAS-PF-13-009,** to the OAAS Regional Office (RO).
2. The PACE provider's Interdisciplinary Team (IDT) will be required to submit a brief **Justification Summary and** supporting documentation from the participant's medical record/plan of care that supports the request for Deemed Continued Eligibility (Refer to OAAS PF 13-009 request form). Supporting documentation includes any information that will demonstrate that, in the absence of PACE services, the participant would reasonably be expected to experience a decline in functional abilities or health to the degree that he/she would meet nursing facility level of care criteria within six (6) months. Examples of **supporting documentation** may include, but are not limited to:

    a. Diagnosis of a chronic, and/or disabling condition;

    b. Physician and/or nursing progress notes documenting the treatment and impact of same on chronic, and/or disabling condition(s);

    c. List of services currently provided to the participant (e.g., PT, OT, dietary management, blood pressure checks, etc.);

    d. Frequency of medical appointments and/or frequency of medical treatments/interventions that point to unstable medical condition that must be treated, and or monitored to avoid complications.

3. A copy of the participant's Plan of Care must accompany the Request for Deemed Continued Eligibility.

B. Responsibilities of OAAS RO Staff

1. OAAS RO staff will review the submitted documentation to determine if the:

a. Participant has a need that requires the services rendered at the PACE center;

b. Participant's health status is unstable, chronic, and/or disabling;

c. Participant's current health status is maintained, at least partially, because of the services PACE currently provides; and;

d. Participant's health and/or functional status are likely to decline over the next six (6) months without PACE services.

2. OAAS RO will review all documentation and respond within ten (10) business days upon receipt of the request and all supporting documentation.

3. As part of the decision making process OAAS may request an onsite visit to meet with the participant, conduct its own level of care assessment and/or request additional information.

4. If OAAS deems continued eligibility, the PACE provider will be notified in writing via **Deemed Continued Eligibility Form – OAAS-PF-13-009**, and enrollment in PACE continues until the next annual reassessment.

5. The PACE provider will continue to conduct annual reassessments for level of care and may request Deemed Continued Eligibility each year as appropriate.

6. If the OAAS RO staff determines that the participant does not meet Deemed Continued Eligibility, a denial notice and appeal rights will be issued to the participant. A copy of the denial notice will be sent to the PACE provider.

7. The OAAS RO shall make a notation in the **Notebook** of the applicable MDS-HC assessment, located in the OAAS assessment

database that states the following: **Deemed Continued Eligibility criteria met on _____ (date goes in blank space) for continuation of PACE program until next annual reassessment.**

8. If the participant files an appeal on or before the date of the proposed adverse action, PACE services shall continue until the Division of Administrative Law renders a decision. OAAS staff will notify the PACE provider via email message to continue services until the appeal is heard and a decision is rendered.

9. If a timely appeal is not filed, services will be terminated effective at the end of the month in which the denial notice was issued.

7.8 Permanent Waiver of Annual Recertification for Program for All Inclusive Care for the Elderly (PACE) Participants

Individuals wishing to access PACE services must initially meet nursing facility LOC eligibility criteria in order to enroll in that program. While annual recertification is a federal requirement, federal regulations also allow the state administering agency to **permanently waiver** this requirement for a PACE participant after the initial certification. In order to do so, the state administering agency must determine that there is no reasonable expectation of improvement or a significant change in the participant's condition because of the severity of a chronic condition, due to the degree of impairment of functional capacity.

7.8.1 Permanent Waiver of Annual Recertification Process Overview

A PACE provider may request a **Permanent Waiver of Annual Recertification after the participant's Initial certification,** and within ninety (90) calendar days from the date of the participant's subsequent annual recertification assessment date. The request for *Permanent Waiver of Annual Recertification* must include evidence of the following:

a. The participant's medical record and plan of care support that the participant has a fragile medical condition(s) with no reasonable expectation of improvement or significant change in the participant's condition due to the severity of a chronic condition or the degree of functional capacity (e.g., nearing end of life, living with a chronic progressive, irreversible, disease, including, but not limited to diagnoses of End Stage Renal Disease [ESRD], Chronic Heart Failure [CHF], Amyotrophic Lateral Sclerosis [ALS])**, OR;**

b. the participant is **permanently** residing in a nursing facility

As part of the decision making process, OAAS may request an onsite visit to meet with the participant, conduct its own level of care assessment and/or to request additional supporting information.

7.8.2 Permanent Waiver of Annual Recertification Procedure

The procedures noted below will be used to determine if the Permanent Waiver of Annual Recertification criteria is met for PACE participants.

A. PACE Provider Responsibilities:

1. The PACE provider will submit a request for a *Permanent Waiver of Annual Recertification* on **OAAS-PF-13-009 form** to the OAAS Regional Office**, for participants who meet the above noted criteria,** within **ninety (90)** calendar days from the date of the participant's annual recertification assessment date.

2. The PACE Interdisciplinary Team (IDT) will provide a brief **Justification Summary Statement** on OAAS-PF-13-009 form that includes the reason(s) why the participant meets the Permanent Waiver of Annual Recertification criteria, as described in this policy.

3. Supporting documentation from the participant's medical record, and Plan of Care (POC) must be included to support the **Justification Summary Statement**. Supporting documentation includes any information that clearly demonstrates that 1) the participant has a fragile medical condition(s) with no reasonable expectation of improvement or significant change in the participant's condition due to

the severity of a chronic condition or the degree of functional capacity (e.g., nearing end of life, living with a chronic progressive, irreversible, disease, including, but not limited to diagnoses of End Stage Renal Disease [ESRD], Chronic Heart Failure [CHF], Amyotrophic Lateral Sclerosis [ALS])**, OR** 2) the participant is **permanently** residing in a nursing facility.

4. Supporting documentation will include 1) a diagnosis of a chronic, and/or disabling medical condition with no reasonable expectation of improvement or significant change in the participant's condition due to the severity of a chronic condition or the degree of functional capacity (e.g., nearing end of life, living with a chronic progressive, irreversible, disease, including, but not limited to diagnoses of End Stage Renal Disease [ESRD], Chronic Heart Failure [CHF], Amyotrophic Lateral Sclerosis [ALS])**, OR** 2) evidence that the participant is a permanent resident of a nursing facility, **and** 4) a copy of the participant's Plan of Care (POC).

5. Once the OAAS Regional Office receives and reviews the request and supporting documentation, they may determine that additional supporting documentation is needed from the PACE provider before a final determination can be reached. **If this occurs, the PACE provider must submit the requested information no later than (5) five business days from the date of receipt of OAAS' request.** If OAAS does not receive the requested information by the required timeline, the OAAS will proceed with the denial process, as applicable.

6. If OAAS approves the PACE provider's request for a Permanent Waiver of Annual Recertification, **PACE will no longer be required to conduct an annual MDS-HC reassessment on that participant** for level of care determination, unless otherwise requested by OAAS.

B. Responsibilities of OAAS Regional Office (RO) Staff

1. OAAS RO staff will:
   a. review the submitted request for *Permanent Waiver of Annual Recertification*, Justification Summary Statement *(OAAS-PF-13-009)*and supporting documentation, including the participant's POC;
   b. determine if the submitted Justification Summary Statement and supporting documentation is adequate to support the request in accordance with the eligibility criteria described in this policy;
   c. determine if an on-site visit is warranted.

2. OAAS RO staff will respond within ten (10) business days from receipt of an adequate Request for *Permanent Waiver of Annual Recertification* form (**OAAS-PF-13-009)**, and supporting documentation, including the participant's POC.

3. If OAAS RO determines that the participant meets the Permanent Wavier of Annual Recertification eligibility criteria described in this policy, the PACE provider and PACE participant will be notified in writing by the OAAS (OAAS notifies provider via the *Permanent Waiver of Annual Recertification* form **[OAAS-PF-13-009]**, and the participant's Level of Care eligibility requirement will be waived permanently, unless otherwise determined by OAAS).

4. The OAAS RO will make a notation in the **Notebook** of the applicable MDS-HC assessment, located in the OAAS assessment database, that states the following:

   Permanent Waiver of Annual Recertification eligibility criteria met on _____ (date goes in blank space).

   If the OAAS RO staff determines that the participant does not meet the Permanent Wavier of Annual Recertification eligibility criteria, and **the participant does not meet nursing facility level of care on any one Pathway, or on Deemed Continued Eligibility, a denial for continuation of PACE services will be issued by OAAS Regional Office.**

5. a denial notice and appeal rights will be issued to the participant. A copy of the denial notice will be sent to the PACE provider.

6. The OAAS RO will make a notation in the **Notebook** of the applicable MDS-HC assessment, located in the OAAS assessment database, that states the following:

   Request for Permanent Waiver of Annual eligibility criteria and supporting documentation, including participant's POC, were reviewed by OAAS. Criteria for Permanent Waiver of Annual Recertification <u>not met</u> on

_____ (date goes in blank space) (Include all actions on the part of OAAS in making this determination, e.g., on-site visit to meet with PACE participant/staff, follow up telephone conversations/emails requesting more information, etc.).

7. If the participant files an appeal on or before the date of the proposed adverse action, PACE services shall continue until the Division of Administrative Law (DAL) renders a decision. OAAS staff will notify the PACE provider via email message to continue services until the appeal is heard and a decision is rendered.

8. If a timely appeal is not filed, services will be terminated effective at the end of the month in which the denial notice was issued.

8.0 Degree of Difficulty Questions (DDQs) Overview

The DDQ process takes into consideration the degree of difficulty (as described in this Section) that an individual may be experiencing in completion of the ADLs. The DDQ process may be used during an Initial Assessment if the criteria described in this section are met. DDQs will not be routinely applied during reassessments, unless the individual meets the extenuating circumstances criteria described in this section of the manual.

8.1 Use of DDQs with LOCET

The DDQs are automatically displayed on the ADL screen Section of the automated OPTS LOCET when an individual's response equals a code of "Independent" on any of the ADLs on the LOCET. OAAS trained SPOE contractor intake staff is prompted to ask if the individual has difficulty in the completion of that particular ADL. If the individual response is "Yes," an additional set of questions appear on the LOCET screen. An example of how this item appears follows:

Individual is coded as "Independent" on the LOCET for the ADL of Toilet Use. The

LOCET Screen displays: *Do you have trouble with using the toilet?* If the SPOE contractor Telephone Specialist selects a response of "Yes," the following set of questions appear on the LOCET screen, and the Telephone Specialist must ask and determine the most appropriate answer from the selection shown below:

I have a little difficulty, or
I have a lot of difficulty

The OAAS Participant Tracking System (OPTS) contains an enhanced version of the LOCET that enables this information to be used in the final LOC determination process as applicable.

8.2 USE OF DEGREE OF DIFFICULTY QUESTIONS (DDQS) TO DETERMINE LOC ON INITIAL MDS-HC

The certified assessor must apply the DDQ process during the MDS-HC LOC determination process, per the protocol described below:

- **Effective August 1, 2011,** the DDQs process described in this Section of the manual took the place of what was commonly referred to as the "0/8 Protocol" for determining if a person met the Level of Care (LOC) eligibility criteria on the **Activities of Daily Living (ADL) Pathway** (PW) when he/she did not *trigger* the ADL pathway on the MDS-HC as described in this Section of the manual.

- The DDQs are used on **Initial** MDS-HC assessments where the applicant:

  1) does not trigger the ADL, Cognitive Performance, or Behavior pathway(s), **and**

  2) the certified assessor determines that the individual is experiencing difficulty in completion of the ADLs, as described in the steps below:

8.3 PROCESS STEPS FOR USE OF DDQS ON MDS-HC

1. The certified assessor determines if the individual has met LOC eligibility criteria in the ADL (see Subsection 5.1 of this manual), Cognitive Performance (see Subsection 5.2 of this manual), or on the Behavioral pathway (see Subsection 5.3 of this manual). If the individual has not met LOC on any of those pathways, proceed to step 2 below.

2. Determine if the individual has a score of "0" (Independent) on any of the four (4) late-loss ADLs of Toilet Use, Transferring, Bed Mobility or Eating. Make a determination if there are circumstances present which may cause the person to have difficulty in the self-performance of those late-loss ADLs. If the conditions described in steps 1 and 2 of this Subsection are true, the certified assessor will apply the DDQs, as described in steps 4 through 7 below.

3. The Degree of Difficulty Questions (DDQs) you (certified assessor) will use, are as follows:

Degree of Difficulty Questions:

- *Do you have trouble with_____?: (The assessor will use items **from a) through d) below** to fill-in the name of the ADL where a zero was scored on the MDS-HC)*

  *a) **positioning yourself in bed** (including moving to and from lying position, turning from side to side, and positioning body while in bed);*

  *b) **eating** (including taking in food by any method, including tube feeding - how person actually consumes food - excludes meal preparation);*

  *c) **transferring** from one surface to another (including moving to and between surfaces – to/from bed, chair wheelchair, standing position – excludes to/from bath/toilet);*

  *d) **using the toilet** (including using the toilet or commode, bedpan, urinal, transferring on/off the toilet, cleaning self after toilet use*

or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.

4. *Ask these questions individually for each of the **late loss ADLs** where the person **has scored a "0", Independent, and where you determined the person is experiencing some degree of difficulty in completing that ADL.***

   If the response is "Yes" – ask "How hard is it for you to do this activity?" Ask the individual to choose from the following statements in answering this question:

   - **I have a little difficulty**
   - **I have a lot of difficulty**

- A response of – **"I have a *lot of difficulty,"*** will indicate the person meets the LOC ADL pathway via application of the DDQs.

  1) **Examples of "a little difficulty**" would be scenarios where the person is completing the ADL, but may have some pain, weakness or must compensate by using furniture or assistive devices to steady him/herself. Some examples follow:

     - "I use the bathroom by myself OK, but sometimes I have a hard time getting up to a standing position again afterwards. But I manage OK."

     - "I can use the bathroom OK, but I don't quite make it sometimes." A Good follow up question: "Do you get your clothing wet or just damp?" If the response is "It's damp", code as "a little difficulty".

     - "I can sit up in bed by myself, but it takes me a little while to get my pillows just right to keep myself supported."

     - "I can turn myself in bed, but my hip hurts me a little if I move too fast."

- "I can feed myself alright, but I drop food sometimes. Just messy, I guess." A Good follow-up question: "Have you lost weight unintentionally in the last 6 months?" If the response is "no", code at "a little difficulty".

- "I can get up from my chair OK, but I have to hold onto the arms of the chair for support because my legs don't have the strength they used to."

- "I can get up from my chair, but I have to rock myself back and forth a couple of times to get up because I don't have a lot of strength in my legs."

- "I can get out of bed OK, but I have to steady myself on the chair that's beside the bed."

- "When I go from my bed to a chair, it hurts a little when I bend my knees to sit on a low chair, so I try to use a straight back, higher chair to help me with this."

2) **Examples of "a lot of difficulty"** would be scenarios where the person is getting the ADL done, but with marked pain, or failure to complete all of the subtask in the particular ADL, or completion of the ADL in an extended period of time because of medical limitations (e.g., shortness of breath, moderate to extreme pain, exhaustion due to physical/medical limitations, etc.). Some examples follow:

   - "I use the bathroom by myself, but sometimes I cannot get up to a standing position again afterwards because of the pain. I end up waiting a long time between visits to the bathroom because of this."

   - "I can use the bathroom OK, but I don't make it sometimes." A Good follow up question: Do you get your clothing wet or just damp? If the response is "It's wet", code at "a lot of difficulty".

- "I can sit up in bed by myself, but it takes me a long time to move myself to do this. I just don't have the strength anymore."

- "I can sit up in bed by myself, but when I try to do it, I end up with a coughing spell. That happens when I exert myself."

- "I can turn myself in bed if I do it really slowly because of the bad pain I get in my hip and back, especially when my pain medication has worn off."

- "I feed myself, but my hands are so shaky now, it takes me twice as long as it used to because I continually drop food." A Good follow-up question: "Have you lost weight unintentionally in the last 6 months?" If the response is "Yes", code at "a lot of difficulty".

- "I can get up from my chair, but I am winded by the time I can finally stand up. I am really weak."

- "I can get out of bed some of the time, but I have slipped and fallen before because I am unsteady and weak."

- "It takes me several minutes or so to lower myself into my chair to watch TV. The arthritis in my back is just too painful."

8.4 DOCUMENTATION OF DDQ RESULTS IN MDS-HC NOTEBOOK

You must document observations/comments on which you based your decision to use the DDQs. You must also document the person's response to the DDQs in the MDS-HC electronic Notebook.

- **IMPOTANT NOTE:** DO NOT CHANGE the original ADL score of "0", Independent, for the late-loss ADLs where DDQs are applied. Leave it as it was originally scored. The documentation in the MDS-HC electronic Notebook will suffice as verification that the person has met the LOC on the ADL pathway via application of the DDQ process.

8.5 USE OF DDQS FOR DETERMINING LOC ON REASSESSMENT MDS-HCS

The DDQs **will <u>not</u> be routinely used** to determine nursing facility LOC on MDS-HC Reassessments (Annual Reassessments, Follow Up, Status Change), **unless** the criteria noted below is met:

1. The individual does not score at least a "3" (Limited Assistance) on any one of the **late-loss ADLs of Bed Mobility, Transferring, or Toilet Use**, **OR scored** less than a "4" (Extensive Assistance) on the **late-loss ADL of Eating**.

2. The individual did not receive formal (paid) Home and Community-Based Supports (HCBS) during the 3-day ADL look-back period **due to *extenuating circumstances out of his/her control** (e.g., Direct Service Worker did not show up as care planned); **AND**

3. You determine that the individual is experiencing difficulty in self-performance of one or more of the four late-loss ADLs coded as "0", Independent, in Section H.2. of the MDS-HC Reassessment.

The extenuating circumstances that lead to use of DDQs on the Reassessment MDS-HC, **AND** documentation supporting the degree of difficulty response must be <u>clearly documented in the MDS-HC electronic Notebook</u> in order for the person to meet the ADL pathway criteria **via application of the DDQS**.

- **<u>IMPOTANT NOTE</u>:** The original ADL score of "0", Independent, for the late-loss ADLs where DDQs are applied, <u>must not be changed</u>. The documentation in the MDS-HC electronic Notebook will suffice as verification that the person has met the ADL pathway LOC criteria **via application of the DDQ process**.

8.5.1 * EXTENUATING CIRCUMSTANCES DEFINED

1) For the purposes of Level of Care Review process on reassessment MDS-HCs, "extenuating circumstances" are defined as follows:

- Circumstances which are **unexpected (i.e., not usual)**, significantly disruptive and beyond an individual's control, and which may have affected his/her performance of Activities of Daily Living during the specified look-back period.

2) A long term condition or problem will not be treated as extenuating circumstances in relation to application of Degree of Difficulty Questions (DDQs) on MDS-HC Reassessments unless it can be shown that the condition or problem was exacerbated by circumstances beyond the participant's control.

3) It is the responsibility of the participant to notify his/her Support Coordinator/Assessor as early as possible when he/she is not receiving services as documented and agreed upon on the participant's Plan of Care (POC), or regarding any problem areas affecting his/her condition/services. In this way the certified assessor can ensure that the problem areas are assessed and addressed in an efficient and timely manner.

4) It is expected that participants/responsible representatives, with the involvement and assistance of the certified assessor, will take reasonable steps to avoid **foreseeable** problems, such as a Direct Service Provider/Worker not showing up, or not providing services as documented in the participant's Plan of Care.

8.6 LT-PCS Programmatic Eligibility Using DDQs

Effective **August 1, 2011**, individuals who meet the LOC eligibility criteria via application of the DDQ process as described in Section 8.0 of this manual **will also be determined to meet LT-PCS Programmatic criteria. This must be documented in the MDS-HC notebook** (e.g., LT-PCS program criteria met via application of DDQs).

9.0 Transitioning Between Programs

This Section describes general LOC policies governing transitioning between HCBS programs, from nursing facilities to HCBS and from Hospitals to HCBS. Specific program requirements are not addressed in this manual, therefore, program manuals should be referenced as needed.

9.1 TRANSITIONING FROM ONE HCBS PROGRAM TO ANOTHER HCBS PROGRAM

If an individual wishes to transition from one OAAS operated long-term care program to another, he/she must meet on at least one of the LOC pathways described in Section 5.0 of this manual, or meet via use of the DDQ process described in Section 8.0. An "initial" MDS-HC assessment shall be performed in order to make this determination.

9.2 TRANSITIONING OUT OF A NURSING FACILITY TO HCBS

Individuals transitioning from a nursing facility to an OAAS operated HCBS must meet functional/medical level of care eligibility requirements as determined by the MDS-HC assessment.

The MDS-HC assessment is performed prior to the individual transitioning out of the nursing facility as a means of assuring the individual meets the nursing facility level of care functional/medical eligibility requirements, he/she can safely transition to the HCBS of his/her choice, and for the development of an individualized plan of care that considers the person's choices and preferences.

All program requirements must be met, and the proper protocols must be followed in order to assure that the individual will continue to meet Medicaid financial eligibility requirements once he/she transitions from the nursing facility to the community (refer to program policy manuals for specific procedures which are to be followed regarding verification of continued Medicaid financial eligibility post transition from nursing facility to the community).

These individuals will be required to meet nursing facility level of care upon initial assessment and reassessment, as specified in state program and federal rules and regulations.

9.3 TRANSITIONING FROM A HOSPITAL TO HCBS

Individuals who are hospitalized at the time they call the contracted SPOE and who wish to transition from the hospital setting to an ADHC Waiver may do so if:

- they have had at least one overnight stay in a hospital within the prior 30 days;
- there is an ADHC Waiver slot available;
- he/she meets functional/medical (LOC) eligibility via the MDS-HC;
- he/she meets ADHC program requirements.

Individuals who are hospitalized at the time they call the SPOE contractor, and who wish to access LT-PCS services must:

- already be Medicaid eligible at the time of the initial SPOE contact;
- meet LOC eligibility on the LOCET Screening tool;
- Meet Initial Targeting Criteria (an LT-PCS Program requirement);
- be assessed via the MDS-HC in their home environment (i.e., place of residence) once they exit the hospital setting;
- meet LOC verification on the MDS-HC;
- meet all LT-PCS Program requirements.

9.4 TRANSITIONING FROM A HOSPITAL TO A NURSING FACILITY

Individuals wishing to transition from a hospital setting to a nursing facility setting must:

- meet LOC eligibility on the LOCET;
- Complete the Pre Admission Screening and Resident Review (PASRR) Level I, and meet its requirements prior to being admitted in to the nursing facility;
- Continue to meet LOC requirements per state and federal rules and regulations.

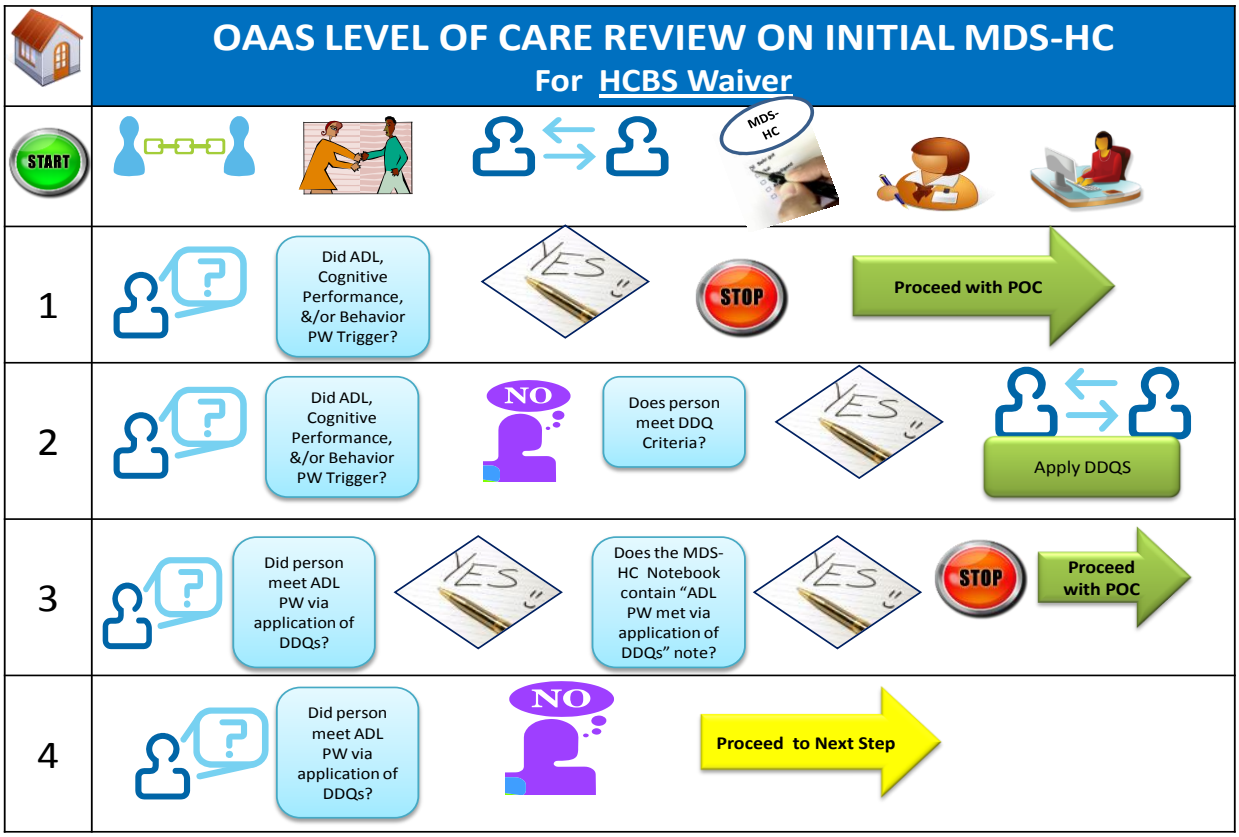
9.5 HCBS PARTICIPANT TRANSITIONING FROM THE COMMUNITY SETTING TO A NURSING FACILITY

Individuals who are currently receiving OAAS operated HCBS Waiver services, LT-PCS State Plan Services, or PACE services **do not require a LOCET screening** in order to transition from an OAAS operated HCBS to a nursing facility.

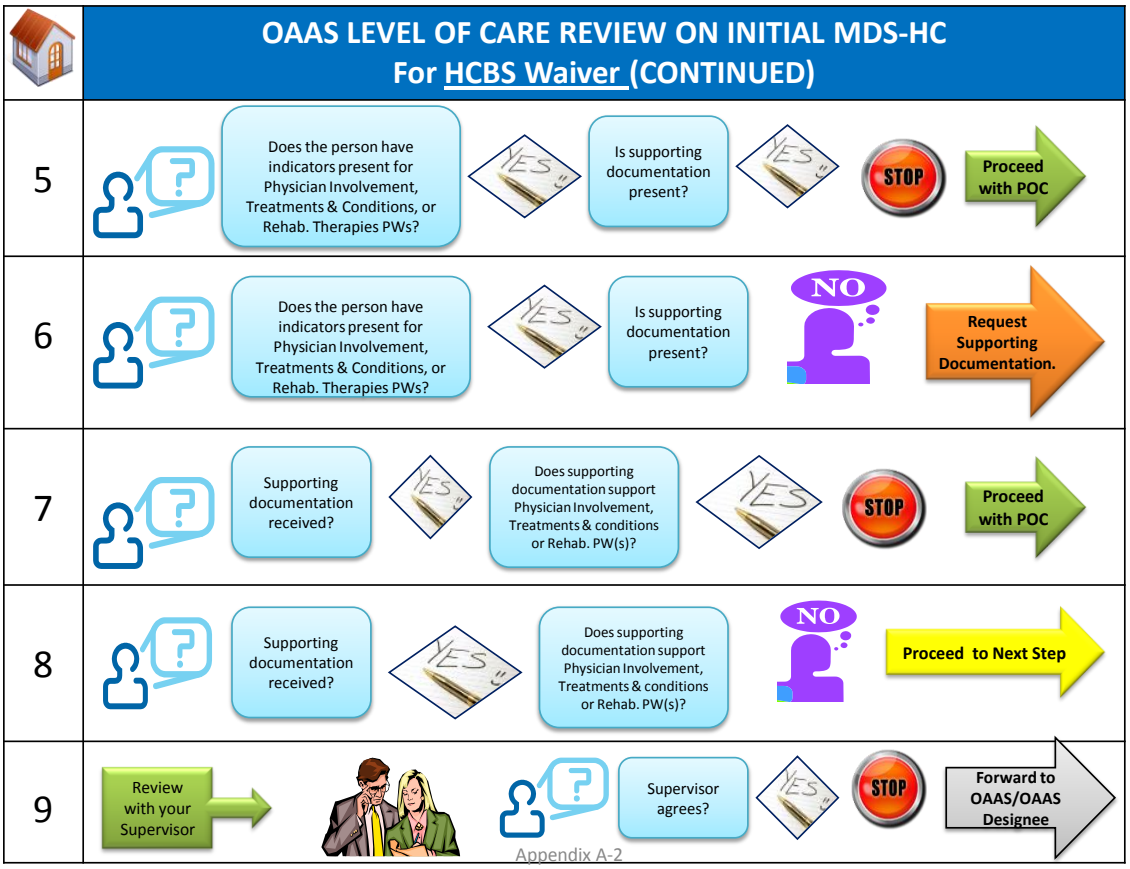
These individuals are determined to meet the required nursing facility level of care eligibility criteria **via the MDS-HC LOC verification process for HCBS**. However, in accordance with state and federal requirements, a PASRR Level I must be completed by the admitting nursing facility prior to the individual being admitted to the nursing facility of their choice.

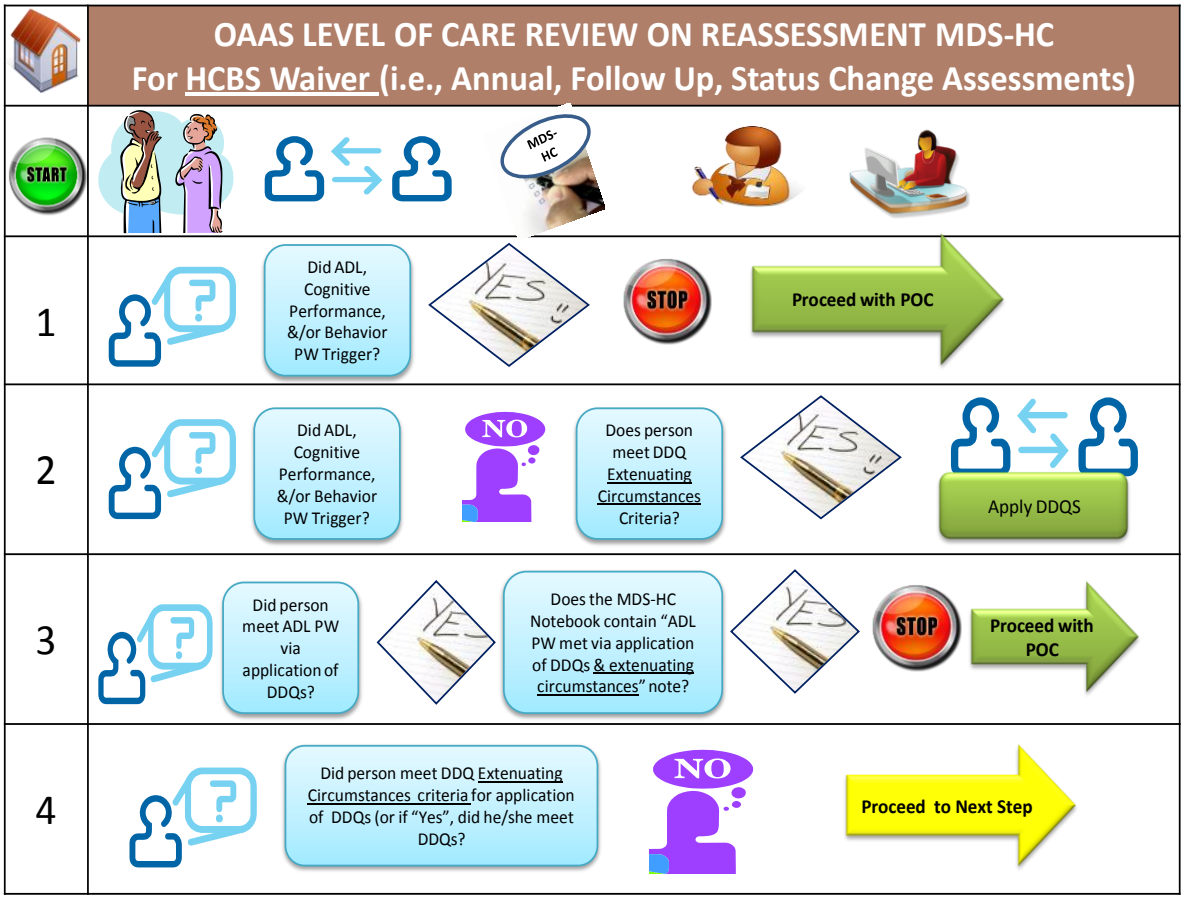
Individuals transitioning from the community setting to a nursing facility may be approved for time limited stays, per state and federal rules and regulations. (Refer to OAAS' Nursing Facility Admissions program Chapter for more detailed information regarding operational procedures).

APPENDIX A
WAIVER HCBS SLIDES

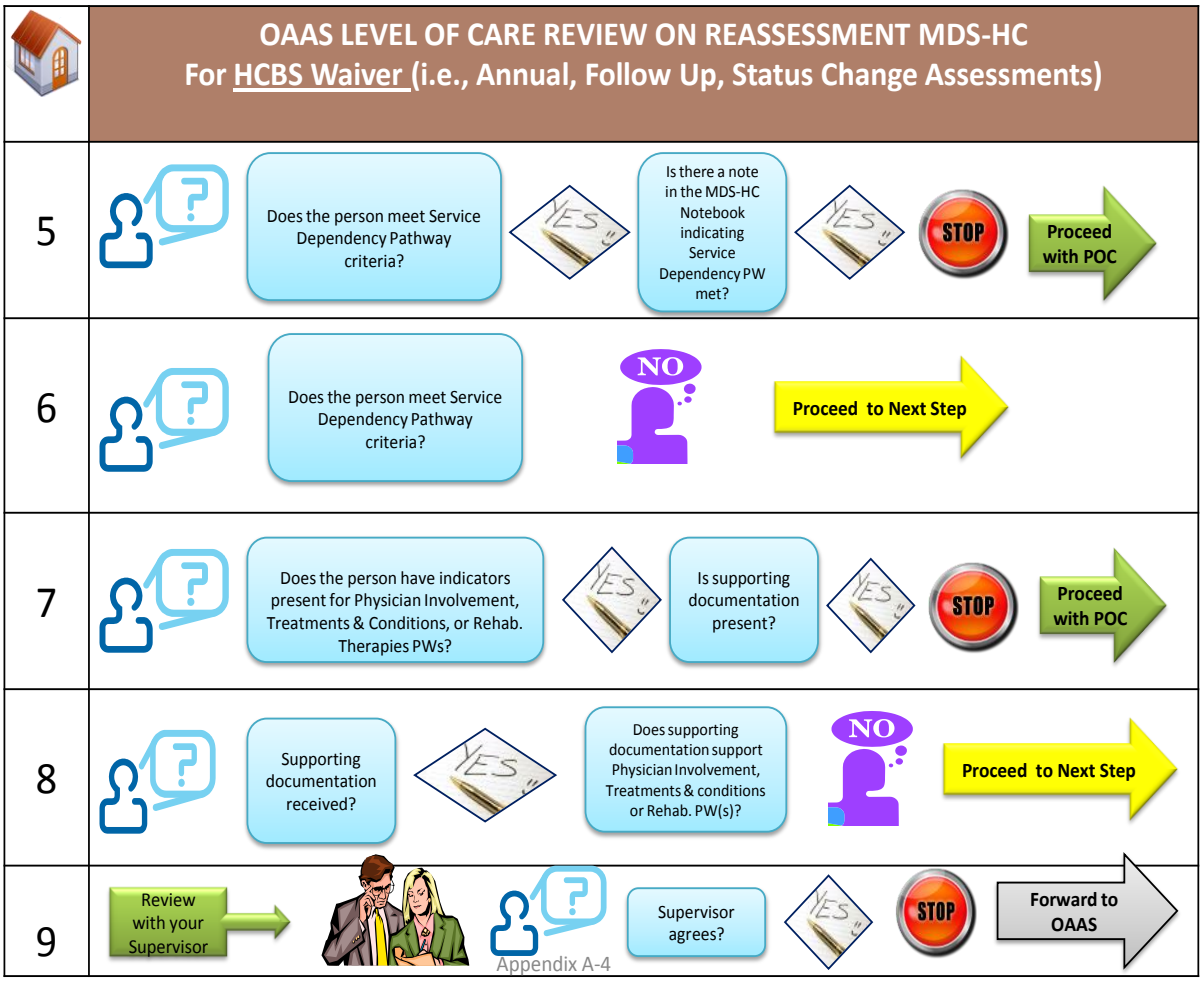

OAAS LEVEL OF CARE REVIEW ON INITIAL MDS-HC
For HCBS Waiver
START
MDS-HC
1
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
YES
STOP
Proceed with POC
2
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
NO
Does person meet DDQ Criteria?
YES
Apply DDQS
3
Did person meet ADL PW via application of DDQs?
YES
Does the MDS-HC Notebook contain "ADL PW met via application of DDQs" note?
YES
STOP
Proceed with POC
4
Did person meet ADL PW via application of DDQs?
NO
Proceed to Next Step

Appendix A-1


OAAS LEVEL OF CARE REVIEW ON INITIAL MDS-HC
For HCBS Waiver (CONTINUED)
5
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
YES
STOP
Proceed with POC
6
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
NO
Request Supporting Documentation.
7
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
YES
STOP
Proceed with POC
8
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
NO
Proceed to Next Step
9
Review with your Supervisor
Supervisor agrees?
YES
STOP
Forward to OAAS/OAAS Designee
Appendix A-2

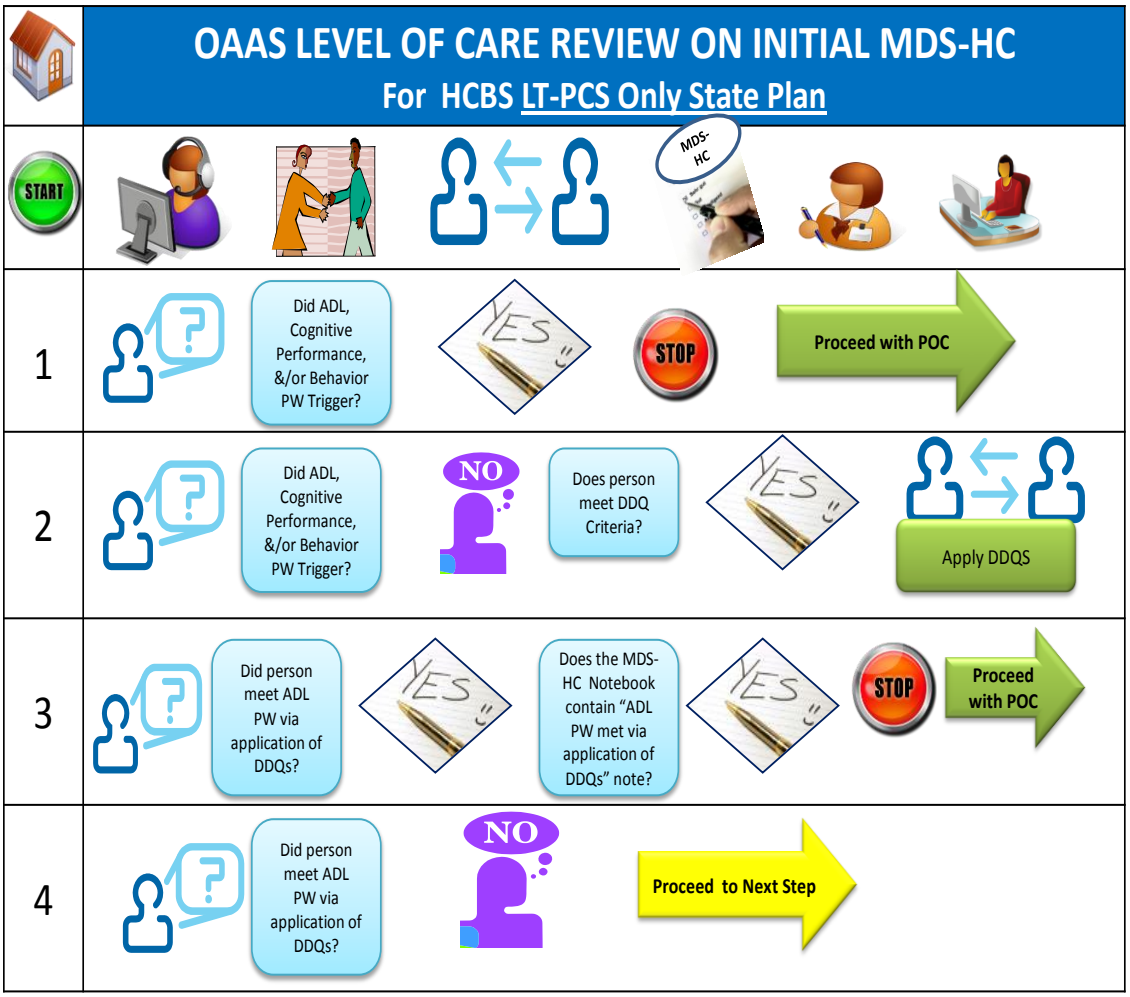

OAAS LEVEL OF CARE REVIEW ON REASSESSMENT MDS-HC
For HCBS Waiver (i.e., Annual, Follow Up, Status Change Assessments)
START
MDS-HC
1
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
YES
STOP
Proceed with POC
2
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
NO
Does person meet DDQ Extenuating Circumstances Criteria?
YES
Apply DDQS
3
Did person meet ADL PW via application of DDQs?
YES
Does the MDS-HC Notebook contain "ADL PW met via application of DDQs & extenuating circumstances" note?
YES
STOP
Proceed with POC
4
Did person meet DDQ Extenuating Circumstances criteria for application of DDQs (or if "Yes", did he/she meet DDQs?
NO
Proceed to Next Step

Appendix A-3

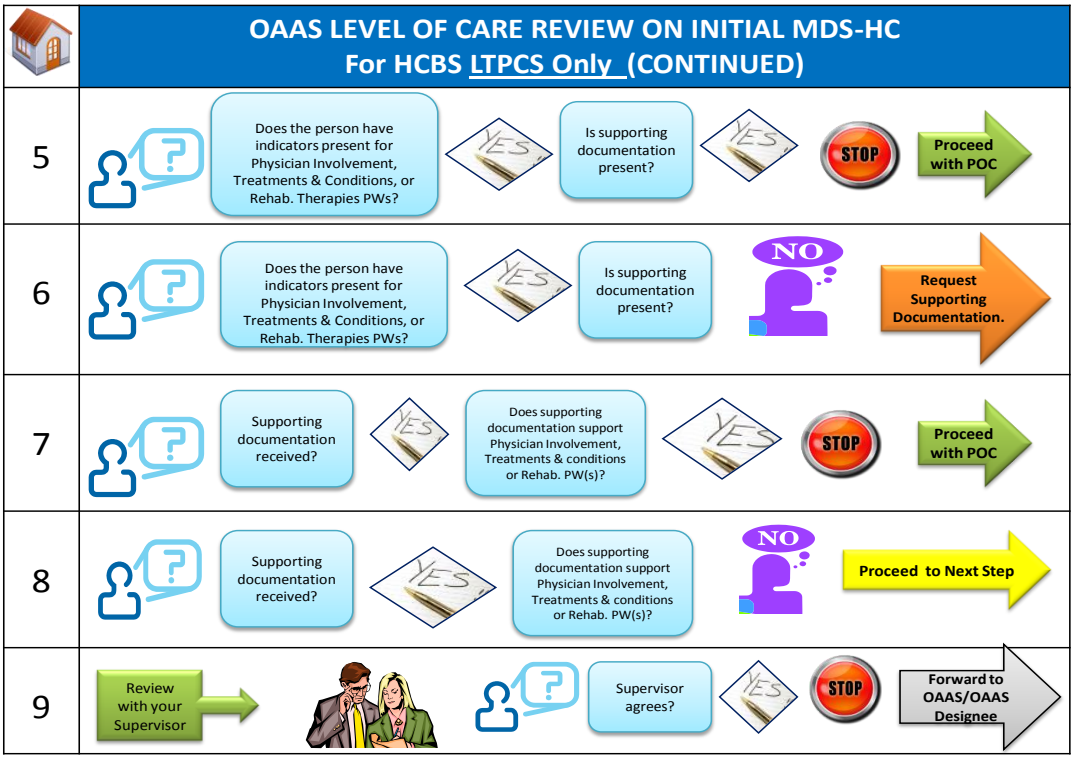

OAAS LEVEL OF CARE REVIEW ON REASSESSMENT MDS-HC
For HCBS Waiver (i.e., Annual, Follow Up, Status Change Assessments)
5
Does the person meet Service Dependency Pathway criteria?
YES
Is there a note in the MDS-HC Notebook indicating Service Dependency PW met?
YES
STOP
Proceed with POC
6
Does the person meet Service Dependency Pathway criteria?
NO
Proceed to Next Step
7
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
YES
STOP
Proceed with POC
8
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
NO
Proceed to Next Step
9
Review with your Supervisor
Supervisor agrees?
YES
STOP
Forward to OAAS

Appendix A-4

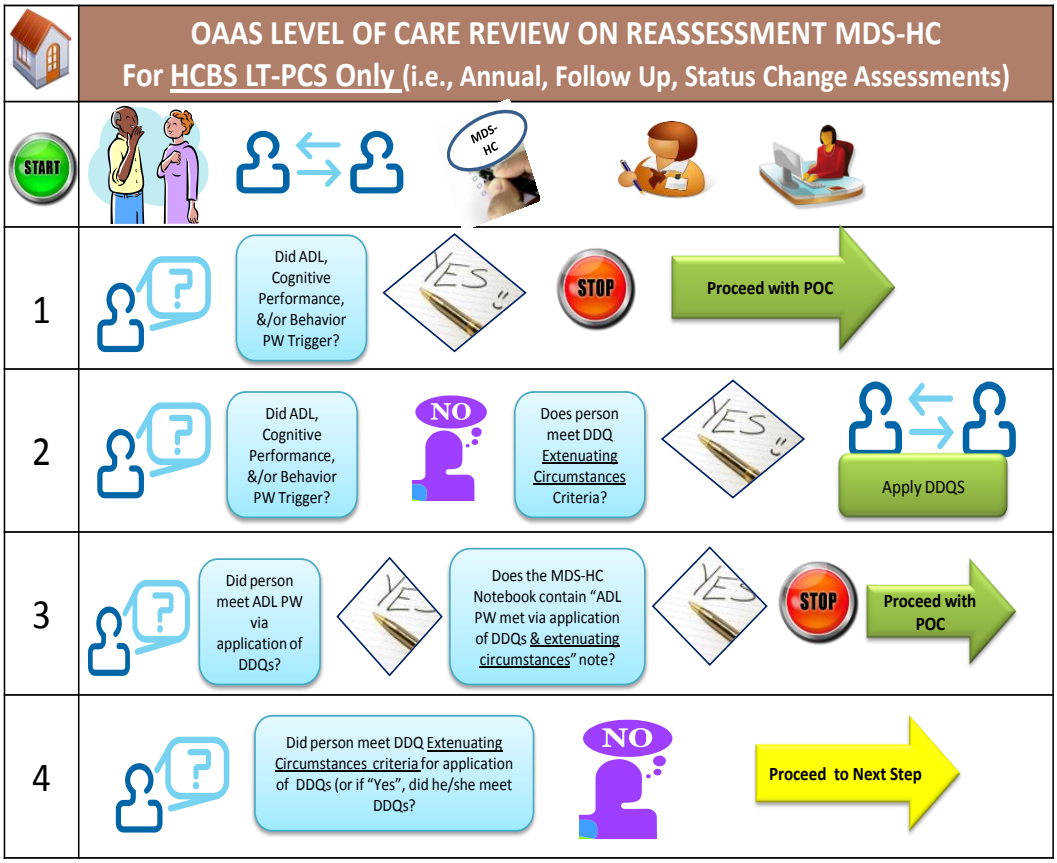
APPENDIX B
LT-PCS ONLY SLIDES


OAAS LEVEL OF CARE REVIEW ON INITIAL MDS-HC
For HCBS LT-PCS Only State Plan
START
MDS-HC
1
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
YES
STOP
Proceed with POC
2
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
NO
Does person meet DDQ Criteria?
YES
Apply DDQS
3
Did person meet ADL PW via application of DDQs?
YES
Does the MDS-HC Notebook contain "ADL PW met via application of DDQs" note?
YES
STOP
Proceed with POC
4
Did person meet ADL PW via application of DDQs?
NO
Proceed to Next Step

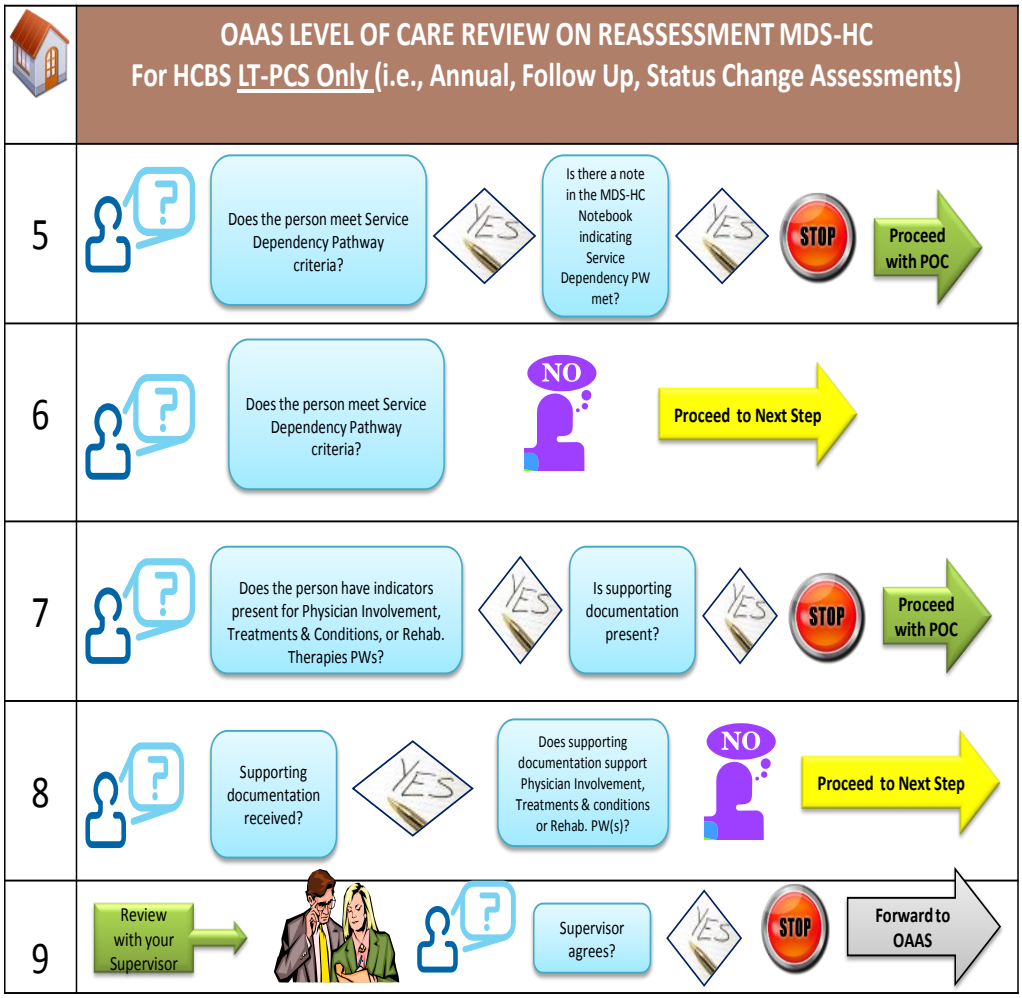
Appendix B-1


OAAS LEVEL OF CARE REVIEW ON INITIAL MDS-HC
For HCBS LTPCS Only (CONTINUED)
5
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
YES
STOP
Proceed with POC
6
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
NO
Request Supporting Documentation.
7
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
YES
STOP
Proceed with POC
8
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
NO
Proceed to Next Step
9
Review with your Supervisor
Supervisor agrees?
YES
STOP
Forward to OAAS/OAAS Designee

Appendix B-2


OAAS LEVEL OF CARE REVIEW ON REASSESSMENT MDS-HC
For HCBS LT-PCS Only (i.e., Annual, Follow Up, Status Change Assessments)
START
MDS-HC
1
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
YES
STOP
Proceed with POC
2
Did ADL, Cognitive Performance, &/or Behavior PW Trigger?
NO
Does person meet DDQ Extenuating Circumstances Criteria?
YES
Apply DDQS
3
Did person meet ADL PW via application of DDQs?
YES
Does the MDS-HC Notebook contain "ADL PW met via application of DDQs & extenuating circumstances" note?
YES
STOP
Proceed with POC
4
Did person meet DDQ Extenuating Circumstances criteria for application of DDQs (or if "Yes", did he/she meet DDQs?
NO
Proceed to Next Step

Appendix B-3


OAAS LEVEL OF CARE REVIEW ON REASSESSMENT MDS-HC
For HCBS LT-PCS Only (i.e., Annual, Follow Up, Status Change Assessments)
5
Does the person meet Service Dependency Pathway criteria?
YES
Is there a note in the MDS-HC Notebook indicating Service Dependency PW met?
YES
STOP
Proceed with POC
6
Does the person meet Service Dependency Pathway criteria?
NO
Proceed to Next Step
7
Does the person have indicators present for Physician Involvement, Treatments & Conditions, or Rehab. Therapies PWs?
YES
Is supporting documentation present?
YES
STOP
Proceed with POC
8
Supporting documentation received?
YES
Does supporting documentation support Physician Involvement, Treatments & conditions or Rehab. PW(s)?
NO
Proceed to Next Step
9
Review with your Supervisor
Supervisor agrees?
YES
STOP
Forward to OAAS

Appendix B-4